



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Sentrix Pharmacy and Discount, L.L.C.

Respondent Name

Property & Casualty Insurance Company of Hartford

MFDR Tracking Number

M4-16-3333-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

June 30, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sentrix has not been paid for these services or received any sort of notification or EOBR."

Amount in Dispute: \$2,388.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed services were denied for several reasons, including claim adjustment reason code D84 – 'Per Carrier, treatment denied; not the treating physician.' Dr. Humberto Lopez was the prescribing physician for all medications in dispute ... Dr. Lopez is not the employee's treating doctor and has never been the employee's treating doctor ... Claimant's Treating Doctor in the instant claim is Dr. Juan Yabraian. While a referral was made by Treating Doctor Yabraian to Dr. Marvin Van Hal, no referral was made to Dr. Lopez by either Treating Doctor Yabraian or by Treating Referral Doctor Marvin Van Hal ... neither Treating Doctor Yabraian nor Treating Referral Dr. Van Hal approved of or recommended treatment by Dr. Lopez; neither Treating Doctor Yabraian nor Treating Referral Dr. Van Hal approved or recommended the medications prescribed by Dr. Lopez."

Response Submitted by: White Espey, P.L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2016	Pharmacy Services - Compound	\$2,388.19	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. Texas Labor Code §408.021 establishes entitlement to medical benefits.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline.
 - D84 – Per Carrier: Treatment denied – not the treating physician.
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - 18 – Exact duplicate claim/service
 - 224 – Duplicate charge.

Issues

Is Property & Casualty Insurance Company of Hartford’s reason for denial of payment supported?

Findings

Sentrix Pharmacy and Discount, L.L.C. is seeking reimbursement of \$2,388.19 for a compound dispensed on February 26, 2016. Property & Casualty Insurance Company of Hartford (Property & Casualty) denied the disputed service with claim adjustment reason code D84 – “PER CARRIER: TREATMENT DENIED – NOT THE TREATING PHYSICIAN.” Texas Labor Code §408.021(c) requires that “Except in an emergency, all health care must be approved or recommended by the employee’s treating doctor.”

Review of the submitted information does not support that the disputed service was provided by or recommended by the employee’s treating doctor. Property & Casualty’s denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

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Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	May 10, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.